Arnold Schwarzenegger, Governor

The California Managed Risk Medical Insurance Board
PO Box 2769
Sacramento, CA 95812-2769
(916) 324-4695 FAX: (916) 324-4878



# Managed Risk Medical Insurance Board
# HFP Advisory Panel Meeting
# November 4, 4008
# West Sacramento, California

Members Present: Jack Campana, Martin Steigner, DDS, William Arroyo, M.D., Elizabeth Stanley Salazar, Barbara Orozco-Valdivia, Ellen Beck, M.D., Karen Lauterbach, Liliya Walsh, Anastasia Gaspay

MRMIB Staff: Lesley Cummings, Ernesto Sanchez, Shelley Rouillard, Sheila Nolan, Christina Anderson, Elva Sutton, Theresa Skewes

## Introduction

Jack Campana, Healthy Families Program (HFP) Advisory Panel Chair, opened the meeting by introducing himself and asking the Panel members, staff and the audience to introduce themselves.

## Appointment of HFP Advisory Panel Member

Ernesto Sanchez, Deputy Director of Eligibility, Enrollment, & Marketing Division swore in the two new HFP Advisory Panel subscribers, Liliya Walsh and Anastasia Gaspay.

## Bagley Keene Act

Sheila Nolan, MRMIB Legal Office, reviewed the Bagley Keene Act, and stated that the act is a California statute that states if you are on a state board or commission, a public notice of the meeting and the prepared agenda has to be posted 10 days prior to the meeting. The Advisory Panel meetings do not have closed sessions as opposed the Board which is a government entity that has a lot of power similar to a state department. If there ever is a closed session there are certain rules that must be followed. Multi member boards allow for various backgrounds and view points to come to a consensus on what government should do. Government needs better input to make decisions. The idea behind this law is to allow the public to attend and participate in public discussions; some efficiency is sacrificed to get the consensus. The quorum of members, for Advisory Panel to meet is 8 members. Violation of the law is considered misdemeanor and the public has the right to bring a lawsuit. If an Advisory Panel member would like to get an item on the agenda, they need to notify Mr. Campana and Mr. Sanchez.

Review of Summary

The Panel made a motion to approve the May 6, 2008 Healthy Families Program (HFP) Advisory Panel Meeting Summary with the noted correction.

Mr. Campana made a comment on the discussion of the report of interest on page 4. "He stated that in enrollment data and race ethnicity, 55% are Latino. 19% is other, and after other it's cut in half 10 percent Asian and 10% white. The category other, has been growing rapidly throughout the years. The change Mr. Campana suggested is replacing the term "mixed" families with the term "bi-racial" families. Also the year of the budget update needs to be changed to reflect the year 2008, not 2007.

Board Meeting Update

Mr. Sanchez provided an update on all MRMIB Board meetings since the last Advisory Panel meeting in May 2008. He stated that at the May 21, 2008 MRMIB Board meeting, staff announced that the HFP open enrollment period which usually happens in April to the end of May, will be delayed because of the late budget. The Board approved final adoption of the regulations clarifying coverage of benefits for lead screening. Staff announced they were terminating the contract with Macias and looking to negotiate with APS Health Care on an evaluation on mental health and substance abuse services provided by HFP plans. The Board adopted final regulations which deleted the HFP to the Medi-Cal Bridge. Presumptive Medi-Cal has been implemented to replace the HFP bridge program which only gave kids 2 months of coverage, while the new presumptive eligibility Medi-Cal gives coverage until an eligibility determination is made by the county.

At the June meeting there was an update on health care reform efforts. In 2007 the Governor proposed to do a comprehensive reform of health care. Unfortunately the bill died in the Senate Health Committee in the beginning of 2008 after passing through Assembly. The Governor stated that he wasn't giving up and he will try to push for health care reform in 2 phases. Phase 1, which was to be implemented this year, will address incremental steps with no General Fund costs that will establish a base for larger reform efforts. Phase 2, which will be implemented when the state's fiscal situation has improved, will focus on big ticket items such as coverage expansion, individual mandate, etc.

Mr. Sanchez stated an SCHIP expenditures update was presented to the Board to make them aware of the fact that California's federal allocation in 2008 was not enough to cover all HFP cost. Surplus federal funds and carry over funds were used to fully fund HFP in California in Federal Fiscal Year 2008. The current SCHIP Reauthorization runs through March 2009 because President Bush vetoed 2 other bills that would have expanded SCHIP. Therefore, a temporary extension was approved until March 2009. The Board was notified that HFP is $466 million dollars short on what it takes to fund the program fully in Federal Fiscal Year 2009. The Panel asked whether other states are having the same problems as California. Mr. Sanchez responded stating that in 2008 there were about 17 or 18 states in the same predicament and federal

government provided surplus funds. Some states in the past 10 years have capped their program or created waiting list due to funding shortfalls. Also at the June meeting the Board adopted the final regulations to implement AB 343 (2004) Provisions on Plan Transfers and to Clarify HFP Benefits. Usually there are clarifications if there has been a change to the Knox Keene statute or PERS Benefits Package benchmark.

At the August meeting, the Board took the action of appointing the 2 Panel subscriber members, Liliya Walsh and Anastasia Gaspay. At this meeting the report on the Payment Error Rate Monitoring (PERM) audits were presented which reflects California being one of 17 SCHIP states that participated and the results was identified at .04 percent error rate. The Medi-Cal expansion error rate was 2.65 percent making the combined SCHIP error rate .07 percent. MAXIMUS was acknowledged for their hard work and helping MRMIB achieve its extremely low error rate. California results, along with the other 16 states results, are being used to set a national standard for PERM SCHIP.

At the September meeting MRMIB provided copy of a letter sent from Executive Director Lesley Cummings to Centers for Medicare and Medicaid Services (CMS). On August 17, 2007, federal government sent a directive to SCHIP states that limited ability to expand SCHIP programs by imposing new crowd-out requirements. Ms. Cummings' letter told CMS that California would continue to draw federal SCHIP funds based on its approved state plan with CMS that CMS had overstepped its authority in issuing the directive and that California would not comply with the directive. One week later CMS announced in a public statement that they would not take any enforcement action on the directive. A few bills were signed into law such as SB1379, which provides additional funding to the MRMIP (high risk pool) and the Board received a presentation on the Healthy Families stories from children's' advocates.

Dr. Arroyo asked in regards to the shift of funding that has been approved, which point is the state SCHIP plan approved to allocate money to states? Mr. Sanchez responded that the federal allocation runs through Federal Fiscal Year 2009 and it only authorizes expenditures through March 2009. The new federal administration along with Congress will have to make the decision on SCHIP funding prior to March 2009. Mr. Campana added that several months ago the program would have had to reduce enrollment by about 50,000 if the program did not receive the SCHIP extension and surplus funding. Mr. Sanchez concluded based on the amount being allotted, the program remains $466 million short for the full 2009 federal fiscal year. Staff hopes that the temporary extensions will end and that a long term extension of the SCHIP is completed.

State Legislative Update

Mr. Sanchez reviewed bills that were passed this year and stated bills passed were AB 265 which deals with health plans recessions in the individual market, SB 697 is the balance billing prohibition that prohibits any healthcare provider from balanced billing for any subscriber in the HFP or AIM Programs, and SB1379 provided $10 million to the MRMIP pool based on penalties assessed on plans for recessions in the individual market. Dr. Ellen Beck asked in regards to the federal law that recently passed about

mental health what are the implications. Ms. Rouillard responded that staff is in the process of evaluating it impact because HFP mirrors the CalPERS state employee's benefits therefore we will have to meet with CalPERS to find out how they are going to implement the mental health parity law changes. The panel requested for this topic to be discussed at the next meeting.

HFP Stories

Various Advocacy groups put together stories of HFP families. The panel suggested that MRMIB translate the stories. Mr. Sanchez responded MRMIB staff is not the creator of the HFP stories but will pass along the suggestion to the advocates. There are privacy and confidentiality restrictions against MRMIB providing the public information on any families in the program. The families in the document were found by advocates and signed confidentiality release forms to participate in the advocate's project.

The Panel asked if the program provides families with other options after they no longer qualify for HFP and are turned down in the individual market. Mr. Sanchez responded that if someone is turned down in the individual market, the plans are required to advise them of the Major Risk Program. MRMIB runs the state's high risk pool for the medically uninsurable. The program is not inexpensive, but it provides comprehensive coverage that has annual limits of $75,000 per year, $750,000 lifetime in benefits, and a deductible of $500 annually. The MRMIP premiums on average are about $500 a month per individual. Additionally, on the MRMIB website there are links that list certain condition-related websites that have foundations that provide funding for people with certain chronic disease. MRMIB will review its disenrollment notice when a child ages out of the program and see what referral information is provided.

Federal Budget, Legislation and Executive Branch Activity

Mr. Sanchez stated CMS sent a SCHIP directive (that was previously discussed) that attempts to re-define state flexibility in SCHIP. The directive basically stated SCHIP coverage should be based on gross income without any income deduction or disregards which removes previous state flexibility on how income is evaluated. MRMIB hoped that CMS would not be taking any enforcement action as they indicated in public statement in August 2008. However, two or three weeks ago CMS denied one of the states request to expand its SCHIP to 300% FPL, citing that state was not in compliance with the August 17 directive. Ms. Orozco- Valdivia asked in the current economy, do we believe the employers will increase the health insurance pool. Mr. Campana stated employees that are covered by employer health programs, studies showed that fewer employees are paying for their children's coverage because of cost. The cost of SCHIP is going to go up because more children will be coming into the program because of the lack or cost of dependent coverage.

Reports of Interest

Mr. Sanchez reviewed the reports of interest and stated that the new HFP enrollment reports shows the number of assisted applications has gone up to 34%, 71% of applications go to HFP, 24% went to Medi-Cal, and 5% go to both programs. Almost $1 million has gone out in payments to Enrollment Entities for Application Assistance reimbursements since the last month's report. According to the Long Term Retention Report, most HFP children have been continuously enrolled within the life of the program. About 27% of the children have had a break of at least a year or longer and less than 1% had break of more than 2 months but less than 1 year. Almost 55% stayed in the program until they were no longer eligible due to age. California is the first state to do a Long Term Retention Analysis. The average 1 year retention rate was about 81%; average 2 year retention rate was about 68%; and average 3 year retention rate was about 60%. The average 9 year retention rate was remarkably 28%. During the national study on disenrollments, conducted by the National Academy for State Health Policy (NASHP) found most families are not notifying the state programs that they found new coverage and eventually stop paying their premiums or do not turn in their renewal forms which overestimates disenrollments by approximately 60%. MRMIB is very proud to present the report and is planning to make it a part of the annual HFP retention reports. Lilliya Walsh suggested having younger kids enrolled more than the older kids and to have the HFP and Medi-Cal programs have a solid bright line on income eligibility that unifies families such as if one child qualifies for the program, the others should as well. Mr. Sanchez responded that there have been talks of getting rid of age criteria and making only the FPL criteria. In the Governor's health care reform proposal, it included getting rid of the age breakdown so all children can be covered under one program instead of different programs for different age groups but that proposal did not pass. However, these suggestions would require changes in law and regulations at the state and federal levels.

The Out of Pocket Expenditure Report

Ms. Rouillard reviewed the Out of Pocket Expenditure report and stated that the report shows the amount of out of pocket expenditures the SCHIP families pay for premium and co pays. Under federal law, families cannot pay more than 5% of their annual income on premiums and co pays. This annual analysis is used to determine if any families reach the 5% or if they hit the $250 annual copay maximum. If a family spends more than the maximum $250 on co-payments, as long as there is proof of payment the family will be reimbursed the difference by the plan. There is no statute of limitations on when families have to notify the plan that they have reached the max. Due to the benefits package, there is no way any family should reach the 5% because of the low premiums and co pay maximum. The report shows a trend of less than 1% of kids in HFP reach the co-payment maximum. No family has ever reached the 5% in federal maximum. The maximum amount per child to HFP includes premiums and will increase as of February 1, 2009 history. The Advisory Panel will be notified of the new premiums in the upcoming year.

Traditional and Safety Net Providers

Ms. Rouillard reviewed the Traditional and Safety Net Provider as Primary Care Physician report and stated the report shows the number children in the program that were selected or assigned to a Traditional and Safety Net (T&SN) Provider which is a provider that has historically served low income uninsured children. The report has information on 20 out of 24 plans which does not include the 3 EPO's and Kaiser. The analysis found 57% of children were linked to T&SN provider and about 2/3 selected to have a T&SN provider as opposed to being assigned one by the plan. Subscribers that do not speak English use these providers more often than English speakers. The conclusion of the report is that for ethnic and non-English speakers having these types of providers in the network are important. MRMIB is committed to continuing to ensure that T&SN providers are available to HFP members.

Consumer Assessment of Healthcare Providers and Systems Survey and Young Adult Health Care Survey (CAHPS and YAHCS) Results for 2007

In 2006, MRMIB sent the Young Adults Health Care Survey (YAHCS) for the first time to teens between the ages 13 to 18. The survey was created because MRMIB wanted to hear the teen's opinions on healthcare. The survey had a lower response rate in 2007 compared to that of 2006 partially because it was mailed out in fall when kids are starting school. The YACHS survey showed last year 3% completed survey online. Most rating results show the YACHS survey below national average for Medicaid and SCHIP. A new national average will come out in 2009.

The common response among teens on the survey is that they consider themselves in good health and they are seeing doctors for routine care. The teens are able to communicate with their doctors but studies show they are not getting screened for risky behavior. Very few are getting screening for depression and prevention of risky behaviors. Dr. Beck recommended that a demonstration project have plans demonstrate questions the doctors should ask to get percentage up. Dr. Arroyo asked how we get primary care providers to ask these questions, since there is no money. The panel made suggestions such as awarding the child with items such as movie ticket to get the children to do the survey. Mrs. Nolan suggested sending text messages to teens to remind them of the survey. Mostly all teens have cell phones and are advanced with technology. Another suggestion by the Panel was to look at other plans that are doing a good job in this area or maybe starting a program within the schools, since school staff see the children everyday as opposed to a doctor that might only see a child once a year.

Cultural and Linguistics Services Survey 2007

Ms. Rouillard reviewed the Cultural and Linguistics Services Survey of 2007 and stated there have been areas of improvement in survey such as the decrease in the number of questions from 37 to 17 questions for this year's survey. The questions focus on proficiency of providers and making sure all services are being provided. Questions on training of staff have been included in the survey. Also DMHC has regulations that

require health plans to have language assistance programs and MRMIB will be coordinating with DMHC to evaluate how well plans are providing language assistance.

Open Enrollment Update

Mr. Sanchez reviewed the Open Enrollment Update and stated 2008 Open Enrollment packets have gone out in the mail in early November. In the November and December billing statements there is a subscriber reminder that Open Enrollment packets are coming and should be received in mid November and must be returned by December 31, 2008, if they want to transfer plans. Packets include information on the new premium changes, premium re-evaluation form for those families impacted by the premium change and plan coverage area changes due to plan changes. We expect more plan transfers than in other years because of the plan changes and the premium increase. It is anticipated that the 2009 Open Enrollment process will be getting mailed out in April 2009 on the regular schedule unless we again have a delayed budget with significant program changes. All information regarding HFP Open Enrollment will be included on the HFP website.

Rural Health Demonstration Projects (RHDP)

Ms. Rouillard reviewed the Rural Health Demonstration Projects (RHDP) and stated that $6.2 million dollars were granted Board for funding from 2008 to 2010. Twenty four projects were able to be funded.

Advisory Committee on Quality

Ms. Rouillard reviewed the Advisory Committee on Quality which is a workgroup made up of 20 people from all perspectives coming together to advise the Board and staff on how best to evaluate quality in HFP program. The discussion at the first meeting in September focused on improving and not just measuring quality. Disparities by race and ethnicity, should not be trying to create new measure, should use those that are already out there. Foundations have provided funding for travel to committee. The next meeting of the Committee is in November.

Mental Health Services

Ms. Rouillard discussed the problem about payment for prescription drugs for children with Serious Emotional Disturbance (SED) conditions and stated counties determine if a child has SED. There is no system for counties to bill the state for prescription drugs for children with SED. There are times where the families pay for it, but the counties are responsible for providing services. Currently MRMIB is working with DHCS and DMH to resolve this issue. There are several options that MRMIB is considering such as having a counties bill for prescription drugs in the same way that they bill for prescriptions for Medi-Cal beneficiaries, using the Medi-Cal Fiscal Intermediary (FI). Another option would be to modify the Short Doyle Medi-Cal System to allow reimbursement for prescription drugs to be claimed through that process. Currently, the state and counties

are dealing with system changes, and MRMIB believes this would be a good time to change the process. The other options are to have MRMIB contract with a pharmacy benefits manager or carve SED services back into the plans.

Update on Encounter Data Project

Ms. Rouillard stated MRMIB is developing a data system, but unfortunately have hit a major barrier, which is the Confidentiality of Medical Information Act (CMIA) This law is more restrictive than HIPAA and MRMIB cannot get certain mental health information unless there is a signed authorization from each person. Ms. Cummings commented that our administrative vendor, MAXIMUS also doesn't have access to the file because they are a part of MRMIB. Therefore the project is being placed on hold. Dr. Beck asked if insurers or Medi-Cal have access to the files we are requesting. Ms. Cummings responded that the insurance companies do have access but are prohibited from sharing health records. Medi-Cal does have access to the data as well. MRMIB is exploring different options to try to resolve this problem.

The Panel reviewed the proposed meeting dates for 2009 and meeting was adjourned.